



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-07-4367-01
VISTA MEDICAL CENTER HOSPITAL 4301 VISTA ROAD PASADENA TX 77504	DWC Claim #:
	Injured Employee:
Respondent Name and Carrier's Austin Representative Box #:	Date of Injury:
LIBERTY INSURANCE CORP Box #: 01	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract. This managed care contract exhibits that Vista Medical Center Hospital is requesting reimbursement that is designed to ensure quality medical care is provided and to achieve effective medical cost control. It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services."
"...amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code § 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' 'they are relevant to achieving cost control,' 'they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services."

Amount in Dispute: \$12,919.68

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The entire bill was denied as preauthorization was required but not requested for this service." "Liberty Mutual authorized the provider under Cert#062290174S001001 to perform a right cervical facet joint injection under anesthesia with fluoroscopic guidance at C3-C7." **"The provider did not perform what was requested and authorized."** "The surgeon billed with cpt codes for destrucion [sic] of nerves 64626 and 64627-which are not the same as cervical facet joint injections." "The facility also billed for CPT 64626, Destruction by neurolytic agent, paravertebral facet joint nerve, cervical or thoracic, single level." "The body of the operative report states radiofrequency (RFTC cervical facet joints were performed.-RFTC is not the same as cervical facet injections." "The procedure that was authorized Cervical facet joint injections are not documented in the body of the operative report." "There is no other authorization number on file for RFTC of cervical spine for this date of service." **"The entire bill for radiofrequency was denied as preauthorization was required but not requested, X170."**

Response Submitted by: Sonja Allen, Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
9/5/2006	62, X170, W1, Z652, X129, X598, Z951	Outpatient Surgery	\$12,919.68	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 14, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):

- 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- X170-Pre-authorization was required, but not requested for this service per TWCC rule 134.600.
- Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
- W1-Workers compensation state fee schedule adjustment.
- X129-Procedure not documented in operative report.
- X598-Claim has been re-evaluated based on additional documentation submitted, no additional payment due.
- Z951-We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health.

2. The respondent denied reimbursement for the disputed services based upon "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," "X170-Pre-authorization was required, but not requested for this service per TWCC rule 134.600," and "X129-Procedure not documented in operative report."

Division rule at 28 TAC §134.600(p)(2) effective May 2, 2006, requires preauthorization for "outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

Division rule at 28 TAC §134.600 (f) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section...The request for preauthorization or concurrent review shall...include the: (1) specific health care listed in subsection (p) or (q) of this section; (2) number of specific health care treatments and the specific period of time requested to complete the treatments."

The Division finds that on 8/18/2006 the requestor obtained preauthorization approval for outpatient services for "Injection, anesthetic agent and/or steroid paravertebral facet joint or facet joint nerve." The additional Information notes on the report states "a right cervical facet joint injection under anesthesia w/fluoroscopic guidance at C3-C7."

The requestor billed for two units of CPT code 64626-"Destruction of neurolytic agent, paravertebral facet joint nerve, cervical or thoracic, single level."

The respondent states in the position summary that "The facility also billed for CPT 64626, Destruction by neurolytic agent, paravertebral facet joint nerve, cervical or thoracic, single level." "The body of the operative report states radiofrequency (RFTC) cervical facet joints were performed.-RFTC is not the same as cervical facet injections." "The procedure that was authorized Cervical facet joint injections are not documented in the body of the operative report."

Division rule at 28 TAC §134.600(c) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

The Division finds that the requestor did not obtain preauthorization approval for CPT code 64626; therefore, the carrier is not liable for payment per Division rule at 28 TAC §134.600(p)(2), (f)(1)(2), and (c).

3. The Respondent raised the issue of a PPO contract; however, a review of the submitted EOBs does not support a PPO reduction was taken. The respondent did not submit a copy of a contractual agreement to support this EOB denial; therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
4. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the

requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).

7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The requestor's position statement asserts that “Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services.”
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The Division has previously found that “hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 TexReg 6268-6269. Therefore, the use of a hospital's “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that “The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract...It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services.”
 - The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
 - Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit “A”, dated 04/23/92, which states that “OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES.”
 - The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that “services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database.”
 - The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive “an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database.”
 - No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
 - No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
 - The requestor's position statement further asserts that “amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code § 413.011 as they are ‘relevant to what fair and reasonable reimbursement is,’ they are relevant to achieving cost control,’ they are relevant to ensuring access to quality care,’ and they are ‘highly reliable.’ See 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services.”
 - While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than

for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor’s position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers’ reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers’ methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that preauthorization was not obtained for the services billed in accordance with Division rule at 28 TAC §134.600(p)(2), (f)(1)(2), and (c). The Division further concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

8/8/2011

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.